DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 6

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 1999-2000 $ 180,420,600
b. FFY 2000-2001 $ 120,280,400

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Part 1 Pages 110,112(d),112(f)(1), 113(b),113(b)(1),117(a),117(c),118,120,137,145, 145(b),146,148,148(b),149(e),185,188,188(a), 188(a)(1),188(b),188(b)(1),188(b)(2),226(a),251 252
***SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Part 1 Pages 110,112(d), 112(f)(1),113(b),113(b)(1),117(a),117(c),118 120,137,145,145(b),146,148,148(b),149(e),185, 188,188(a),188(b),226(a),251

No Previous Pages: 188(a)(1),188(b)(1), 188(b)(2),252

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

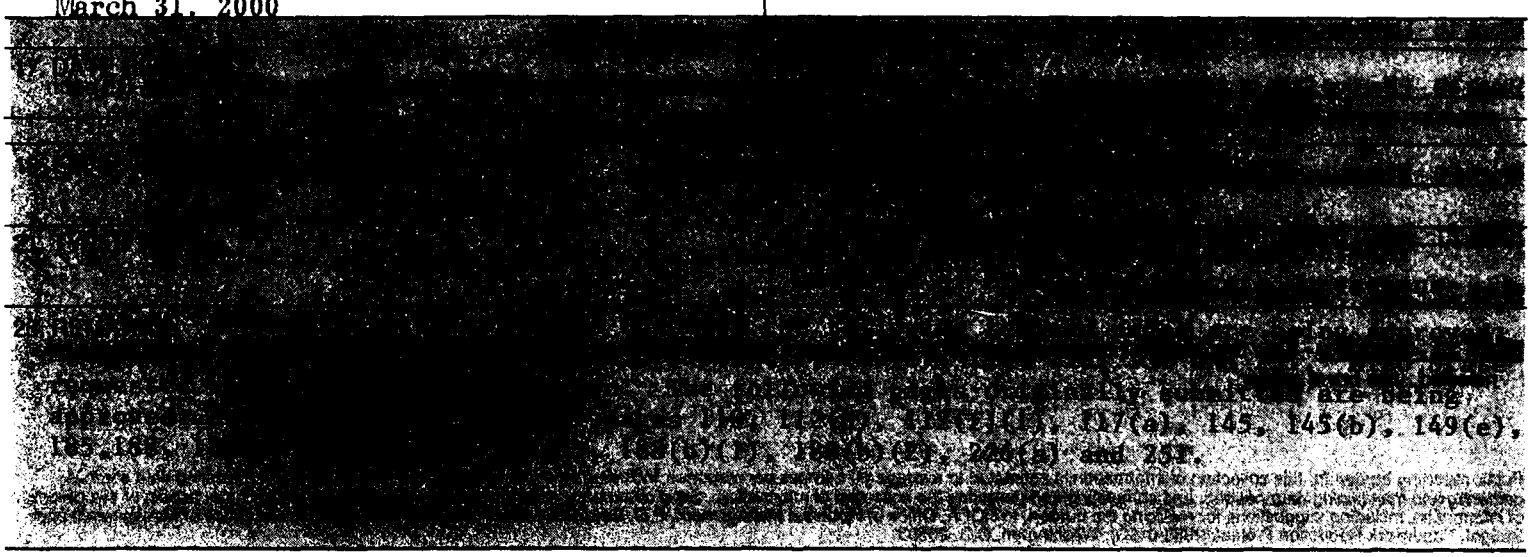
12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Antonia C. Novello, M.D., M.P.H.

14. TITLE:
Commissioner

15. DATE SUBMITTED:
March 31, 2000

16. RETURN TO:
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237



FORM HCFA-179 (07-92)

Instructions on Back

(2) a factor of ¼ percent of a general hospital's trended reimbursable inpatient operating cost as defined in section 86-1.54 of this Subpart, shall be allocated to costs of general hospitals for technology advances, provided, however, this allocation shall not apply for the periods April 1, 1996 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2003;

(3) a factor of ¼ percent of a general hospital's trended reimbursable inpatient operating cost as defined in section 86-1.54 of this Subpart shall be allocated to the costs of general hospitals for increased activities related to quality assurance and patient discharge planning; and

(4) the balance of the one hundred and thirty million dollars after deducting the dollar value of the allocation specified in subclauses (1), (2) and (3) above shall be allocated to costs of general hospitals based on the ratio of each general hospital's 1985 costs incurred in excess of the trend factor between 1981 and 1985 in the following discrete areas, summed, to the total sum of such cost over trend of all general hospitals applied to such balance: malpractice insurance costs, infectious and other waste disposal costs, water charges, direct medical education expenses, working capital interest costs of hospitals that qualified for distributions pursuant to section 86-1.36 of this Supart, costs of distinct psychiatric units excluded from the case based payment, and ambulance costs. For the purpose of this sub-

provided to beneficiaries of title XVIII of the Federal Social Security Act and excluding direct medical education costs.

(b) Effective January 1, 1991 through March 31, 1995 and effective on and after April 1, 1996, $33 million shall be allocated for technology advances and changes in medical practice. Amounts allocated to each general hospital shall be based on a fixed amount per bed determined by multiplying the number of certified inpatient beds for each general hospital as of June 30, 1990 by the result of dividing the $33 million by the sum of the certified inpatient beds for all general hospitals. Provided, however, this allocation shall not apply for the periods April 1, 1996 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2003.

(c) $26 million shall be allocated to costs of general hospitals based on the costs incurred in excess of the trend factor between 1985 and 1989 in the following discrete areas: infectious and other waste disposal costs, universal precautions, working capital interest costs, costs for asbestos removal, costs of low osmolality contrast medic, malpractice costs, water and sewer charges, ambulance costs, service contracts, prosthetic and orthotic devices and costs related to designation as a trauma center and contracted nursing services.

(1) If the 1989 costs incurred in excess of the trend factor between 1985 and 1989 summed for each discrete area for all general hospitals is greater than or equal to $26 million, the $26 million shall be allocated to costs of general hospitals based on the ratio of each general hospital's 1989 costs incurred in excess of the trend factor in such discrete areas, summed, to the total sum of such cost over trend of all general hospitals.

(2) If the 1989 costs incurred in excess of the trend factor between 1985 and 1989 summed for all general hospitals is less than $26 million, the allocated costs to each general hospital

(DRGs) 475,483,540, 701-716 and 798-801.

(b) $63 million shall be allocated to general hospitals for labor adjustments. Such amount shall be allocated as follows:

(1) An amount equal to $55 million shall be allocated for labor cost increases incurred prior to June 30, 1993. Amounts allocated to each general hospital shall be based on the general hospital's share of the statewide total of inpatient and outpatient reimbursable operating costs based on 1990 data excluding costs related to inpatient services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) and excluding direct medical education costs, as determined pursuant to section 86-1.54 (g) (3);

(2) An amount equal to $8 million shall be allocated for labor adjustments to general hospitals located in the counties of Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland, Columbia, Delaware and Westchester, to account for prior disproportionate increases in unreimbursed labor costs. Each general hospital determined pursuant to this subclause shall receive a portion of the $8 million equal to the general hospital's portion of the total inpatient and outpatient reimbursable operating costs based on 1990 data for all hospitals located in the counties identified pursuant to this subclause, excluding costs related to services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) and excluding direct medical education costs, as determined pursuant to section 86-1.54(g)(3).

(c) $55 million shall be allocated for increased activities related to regulatory compliance universal precautions and infection control related to AIDS, tuberculosis, and other infectious diseases including the training of employees with regard to infection control, and for infectious and other waste disposal costs. A fixed amount per bed shall be allocated to the costs of each general hospital based on the total number of inpatient beds for which each hospital is certified as of August 24, 1993. Provided however, this allocation shall not apply for the periods April 1, 1996 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2003.

(d) An amount equal to $3 million shall be allocated to the costs of each general hospital in the following manner and which meet the following criteria:

(1) $250 per bed shall be allocated to the costs of each general hospital having less than 201 certified acute care beds as of August 24, 1993 and classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by Federal law (see 42 U.S.C. section 1395 ww(d) (2) (D) or defined by Federal law (see 42 U.S.C. section 1395 ww(d) (2) (d) or defined as a rural hospital under section 700.2 (a) (21) of

program. Any remaining amount not allocated by March 31, 1996 according to this subparagraph shall be allocated according to clause (c) of subparagraph (ii) of this subdivision.

(iv) Allocations pursuant to this subdivision shall be based on general hospital classifications as of April 1, 1995.

(6)(i) For the period July 1, 1996 through March 31, 1997, the Commissioner shall increase rates of payment, in the aggregate by an amount not to exceed forty-five million dollars for those voluntary non-profit and private proprietary hospitals which qualify for distributions pursuant to paragraph (5) of this subdivision during the period July 1, 1995 through June 30, 1996. Rate adjustments pursuant to this subparagraph shall be allocated among qualifying general hospitals based on each hospital's estimated proportionate share of total funds allocated pursuant to paragraph (5) in effect July 1, 1995 through June 30, 1996.

(ii) For the period September 1, 1997 - March 31, 1998, and April 1, 1998 through March 31, 1999 the Commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed forty-eight million dollars in the aggregate for each such rate period, allocated among those voluntary non-profit and private proprietary hospitals which qualify for distributions pursuant to paragraph (5) of this subdivision during the period July 1, 1995 through June 30, 1996. Rate adjustments pursuant to this subparagraph shall be allocated among qualifying general hospitals based on each hospital's estimated proportionate share of total funds allocated pursuant to this paragraph in effect July 1, 1995 through June 30, 1996.

(iii) For the period September 9, 1999 through March 31, 2000, the Commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed thirty-six million dollars in the aggregate. Such amount shall be allocated among those voluntary non-profit and private proprietary general hospitals which continue to provide inpatient services as of July 1, 1999 under a previous or new name and which qualified for rate adjustments pursuant to paragraph (5) of this subdivision as in effect for the period July 1, 1995 through June 30, 1996 proportionally based on each such general hospital's proportional share of total funds allocated pursuant to paragraph (5) of this subdivision as in effect for the period July 1, 1995 through June 30, 1996, provided however, that amounts allocable to previously but no longer qualified hospitals shall be proportionally reallocated to the remaining qualified hospitals. The rate adjustments calculated in accordance with this subparagraph shall be subject to retrospective reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation, to the extent allowable under federal law, provided however that the department shall not be required to reconcile payments made pursuant to this section applicable to periods prior to September 1, 1997.

(iv) To the extent funds are available, for rate periods April 1, 2000 through March 31, 2003, the commissioner shall increase rates of payment for hospital inpatient services by an amount not to exceed $48 million annually in the aggregate. Such amount shall be allocated among those voluntary non-profit and private proprietary general hospitals which continue to provide inpatient services as of July 1, 1999 under a previous or new name and which qualified for rate adjustments pursuant to paragraph (5) of this subdivision as in effect for the period July 1, 1995 through June 30, 1996 proportionally based on each such general hospital's proportional share of total

funds allocated pursuant to paragraph (5) of this subdivision as in effect for the period July 1, 1995 through June 30, 1996, provided however, that amounts allocable to previously but no longer qualified hospitals shall be proportionally reallocated to the remaining qualified hospitals. The rate adjustments calculated in accordance with this subdivision shall be subject to retrospective reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation, to the extent allowable under federal law, provided however that the department shall not be required to reconcile payments made pursuant to this section applicable to periods prior to September 1, 1997.

(b) Exempt hospitals and units. Payments to hospitals for acute care services that are exempt from DRG case-based payment rates shall be established pursuant to section 86-1.57 of this Subpart. The hospital specific costs identified in subparagraph (a)(1)(ii) of this section shall be apportioned to the exempt unit operating per diem based on the data provided by the hospital. These payments shall include a health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(1) For the period April 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(2) For the period January 1, 1996 through March 31, 1997, a health care services allowance of 1.09 percent of the hospitals non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(c) Alternative level of care payments. Hospitals providing alternative level of care services as defined in section 86-1.50 of this Subpart shall be reimbursed for this care pursuant to the provisions of section 86-1.56 of this Subpart.

(1) A health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58;

(2) For the period July 1, 1995 through December 31, 1995, a health care services allowances of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(3) For the period January 1, 1996 through March 31, 1997, a health care services allowances of 1.09 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in 86-1.58.

(d) For rates of payment for discharges in 1991 and thereafter, a general hospital having less than 201 certified acute non-exempt inpatient beds that is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by federal law (see 42 U.S.C. section 1395 ww (d)(2)(D)) or defined as a rural hospital under state law may choose to have its DRG specific operating cost component be 100 percent of the hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54 (a) of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart, provided however, commencing April 1, 1996 through July 31, 1996 the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group excluding the costs of graduate medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2), shall be reduced by five percent, and commencing August 1, 1996 through March 31, 1997 the reimbursable impatient operating cost component of case based rates of payment per diagnosis-related group, excluding the costs of graduate medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2), shall be reduced by two and five-tenths percent, and commencing April 1, 1997 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2003, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding the costs of graduate medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54 (h)(2), shall be reduced by three and thirty-three hundredths percent to encourage improved productivity and efficiency. In order to exercise this option for 1991 or subsequent rate years, the general hospital shall notify the Department of such election in writing by no later than December first of the preceding rate year or a later date as determined by the Commissioner.

(e) As for discharges on or after April 1, 1995 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2003, the DRG case-based rates of payment for patients assigned to one of the twenty most common diagnosis-related groups, will be held to the lower of the facility specific amount or the average amount, as determined pursuant to subdivision (c) of this section for all hospitals assigned to the same peer group. The twenty most common diagnosis-related groups shall be determined using discharge data two years prior to the rate year, but excluding beneficiaries of title XVIII (Medicare) of the federal social security act and patients assigned to diagnosis-related groups for human immunodeficiency virus (HIV) infection, acquired immune deficiency syndrome, alcohol/drug use or alcohol/drug induced organic mental disorders, and exempt unit of exempt hospital patients.

(f) Effective July 1, 1995 through June 30, 1996, rates of payment for inpatient acute care services shall be reduced by the Commissioner to reflect the elimination of operational requirements previously mandated by law, regulation promulgated in accordance with applicable standards and procedures for promulgating hospital operating standards, the Commissioner, or other governmental agency as follows:

(i) An aggregate reduction shall be calculated for each hospital based upon: the result of eighty-nine million dollars annually for 1995 and trended to the rate year, multiplied by a ratio based upon data two years prior to the rate year, consisting of hospital-specific case-based

education amount determined pursuant to section 86-1.54(g) of this subpart;

(5) plus the value of forty-five percent of the indirect medical education expenses as determined pursuant to section 86-1.54(h)(1)(iv)-(v) of this subpart;

(6) plus the value of fifty-five percent of the indirect medical education expenses reflected in the hospital's peer group average inpatient operating cost per discharge determined pursuant to section 86-1.54(b) of this Subpart;

(i) For discharges on or after April 1, 1997 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2003, the DRG case-based rates of payment shall be the sum of:

(1) an amount, determined pursuant to subdivision (c) of this section, excluding those costs for direct and indirect medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2) respectively, of this subpart;

(2) minus three and thirty-three hundredths percent of the amount determined in accordance with paragraph (1) of this subdivision to encourage improved productivity and efficiency;

(3) plus the value of direct medical education as determined pursuant to section 86-1.54(g) of this Subpart;

(4) minus three and thirty-three hundredths percent of the costs of hospital based physicians reflected in the direct medical education amount determined pursuant to section 86-1.54(g) of this subpart;

(5) plus the value of forty-five percent of the indirect medical education expenses as determined pursuant to section 86-1.54(h)(1)(iv)-(v) of this subpart;

(6) plus the value of fifty-five percent of the indirect medical education expenses reflected in the hospital's peer group average inpatient operating cost per discharge determined pursuant to section 86-1.54(b) of this Subpart;

[(j)] (j) Effective July 1, 1996 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2003, rates of payment for inpatient acute care services shall be reduced by the Commissioner to encourage improved productivity and efficiency by a factor determined as follows:

(1) An aggregate reduction shall be calculated for each hospital based on: the result of eighty-nine million dollars and trended to the rate year on an annualized basis for each year, multiplied by the ratio of hospital-specific case based Medicaid patient days, in a base year two years prior to the rate year, consisting of hospital-specific case-based Medicaid patient days divided by the total of such patient days summed for all hospitals.

(2) The result of each hospital shall be allocated to exempt units within such hospital based on the ratio of hospital specific exempt unit Medicaid patient days to hospital specific total Medicaid patient days of which the result is divided by the hospital specific exempt unit Medicaid patient days to produce a unit of service reduction in the per diem rates of payment.

(3) Any amount not allocated to exempt units shall be divided by case based discharges (or for exempt hospitals by patient days) in the base year two years prior to the rate year, resulting in a per case (or for exempt hospitals a per diem) unit of service reduction in payment rates.

86-1.54 (1/00)
Attachment 4.19-A
Part I

86-1.54 Development of DRG case-based rates of payment per discharge. (a) The hospital-specific average reimbursable inpatient operating cost per discharge shall be determined by dividing hospital-specific non-Medicare reimbursable operating costs determined pursuant to paragraph (1) of this subdivision by non-Medicare discharges determined pursuant to paragraph (2) of this subdivision and dividing this result by the hospital-specific case mix index determined pursuant to paragraph (3) of this subdivision.

(1) Hospital-specific non-Medicare reimbursable operating costs shall be the hospital's 1987 reimbursable operating costs trended to the rate year pursuant to section 86-1.58 of this Subpart including any adjustments made pursuant to section 86-1.52(a)(iii)(a)(iv), and (v) of this Subpart but excluding the following costs:

(i) Medicare costs as defined in subdivision (c) of this section including any costs of a Medicare patient's stay paid for by or on behalf of a secondary payor;

(ii) ALC costs as defined in subdivision (d) of this section;

(iii) exempt unit costs as defined in subdivision (e) of this section;

(iv) transfer costs as defined in subdivision (f) of this section;

(v) short-stay outlier costs as defined in subdivision (f) of this section; and

(vi) high-cost outlier costs as defined in subdivision (f) of this section.

(vii) For rates of payment for discharges occurring on or after April 1, 1995 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2003 the reimbursable base year inpatient administrative and general costs of a general hospital shall include reported administrative and general data, data processing, non-patient telephone, purchasing, admitting, and credit and collection costs. Excluding providers reimbursed on an initial budget basis, such administrative and general costs shall not exceed the statewide average of total reimbursable base year inpatient administrative and general costs. This limitation shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the Commissioner for each general hospital. Reimbursable base year administrative and general costs, for purposes of this paragraph, shall mean those base year administrative and general costs remaining after application of all other efficiency standards.

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to paragraph (a)(3) of this section. The group average wage and case mix adjusted operating cost per discharge shall be based on hospital-specific reimbursable operating costs which shall be calculated as follows:

(1) The following costs shall be subtracted from the sum of the hospital's allowable 1987 reimbursable operating costs trended to the rate year pursuant to section 86-1.58 of this subpart and any adjustments made pursuant to section 86-1.52 (a)(1)(iii)(a), (iv), and (v)(a).

(i) Medicare costs as defined in subdivision (c) of this section including any costs of a Medicare patient's stay paid for by or on behalf of a secondary payor;

(ii) ALC costs as defined in subdivision (d) of this section;

(iii) exempt unit costs as defined in subdivision (e) of this section;

(iv) direct GME costs as defined in subdivision (g) of this section; and

(v) hospital-specific operating costs as defined in subdivision (g) of this section.

(vi) For rates of payment for discharges occurring on or after April 1, 1995 through March 31, 2000 and July 1, 1999 through March 31, [2000] 2003 the reimbursable base year inpatient administrative and general costs of a general hospital shall include reported administrative and general data, data processing, non-patient telephone, purchasing, admitting, and credit and collection costs. Excluding providers reimbursed on an initial budget basis, administrative and general costs shall not exceed the statewide average of total reimbursable base year inpatient administrative and general costs. This limitation shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the Commissioner for each general hospital. Reimbursable base year administrative and general costs, for purposes of this paragraph shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines.

(2) The hospital-specific portion of the $40 million base enhancement specified in section 86-1.52(a)(1)(iii)(b) of this Subpart shall be added to the costs determined for each hospital in

Section 86-1.55

Development of Outlier Rates of Payment.

(a) Short Stay Outliers. Payments for short stay outlier days shall be made at a per diem calculated by multiplying the days of actual length of stay below the short stay threshold by the short stay per diem rates defined in this subdivision. The short stay per diem rate shall be determined by dividing the hospital's DRG case-based rate of payment determined pursuant to section 86-1.52(a)(1) by the hospital's group average arithmetic inlier LOS for the DRG and multiplying the result by the short stay adjustment factor of 150 percent. For rate periods April 1, 1996 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2003, the short stay adjustment factor shall be 100 percent. In cases where the group average arithmetic inlier length of stay for the DRG is equal to one, the short stay adjustment factor shall not be applied. Budgeted capital costs determined pursuant to section 86-1.59 of this Subpart shall be added to the per diem.

(b) Long stay outliers. Payments for long stay outlier days shall be made at a per diem rate calculated by multiplying the days of the actual length of stay in excess of the long stay outlier threshold by 60 percent of the per diem obtained by dividing the group average DRG operating cost per discharge defined in section 86-1.54 (b) of this Subpart by the hospital's group average arithmetic inlier length of stay for the DRG. For rate periods April 1, 1996 through March 31, 1999 and July 1, 1999 through March 31, [2000] 2003, 50 percent of the per diem shall be used in the calculation. This result shall be multiplied by the percent for the group average reimbursable inpatient operating cost determined pursuant to section 86-1.53 of this Subpart. These payments shall include a health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(1) For the period April 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(2) For the period January 1, 1996 through March 31, 1997, a health care services allowance of 1.09 percent of the hospitals non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.614 percent for rate year 1994 and .637 percent of the rate year 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

86-1.58 Trend Factor. (a) The commissioner shall establish trend factors for hospitals to project the effects of price movements on historical operating costs. Rates of payment excluding capital, as calculated pursuant to the provisions of section 86-1.52 of this Subpart, shall be trended to the applicable rate year by the trend factors developed in accordance with the provision of this section for rate periods through March 31, 2000.

(b) The methodology for establishing the trend factors shall be developed by a panel of four independent consultants with expertise in health economics or reimbursement methodologies for health-related services appointed by the commissioner.

(c) The methodology shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for non-supervisory employees. For 1996 through December 31, 1999, the commissioner shall apply the 1995 trend factor methodology.

(d) The commissioner shall implement one interim adjustment to the trend factors, based on recommendations of the panel, and one final adjustment to the trend factors. Such adjustment shall reflect the price movement in the labor and non labor components of the trend factor. At the same time adjustments are made to the trend factors in accordance with this subdivision, adjustments shall be made to all inpatient rates of payment affected by the adjusted trend factor.

(e) Trend factors used to project reimbursable operating costs to the rate period April 1, 1995 to December 31, 1995 shall not be applied in the development of the rates of payment. This section shall not apply to trend factors, adjusted trend factors of final trend factors used for the January 1, 1995 to December 31, 1995 rate period for purposes of projecting allowable operating costs to subsequent rate periods.

(f) Trend factors used to project reimbursable operating costs to the rate period commencing April 1, 1996 through March 31, 1997, shall not be applied in the development of the rates of payment. This section shall not apply to trend factors or final trend factors used for the January 1, 1995 through December 31, 1995 or January 1, 1996 to March 31, 1996 rate period for purposes of projecting allowable operating costs to subsequent rates periods.

(g) Trend factors used to project reimbursable operating costs to rate periods commencing July 1, 1999 through March 31, [2000] 2003 shall reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

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